Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 9/29/10
Amount 1850.00

Mt Lebanon Personal Care Home
21060100002

I. IDENTIFICATION

Name James S. Taylor Memorial Home

Address 1015 West Magazine Street

City/County/Zip Louisville / Jefferson / 40203

Telephone number (502) 589-0727

Administrator Stephanie Mathis

RECEIVED
SEP 23 2010
See Attached
OFFICE OF INSPECTOR GENERAL

Date facility operation began at current address 10-13-1982

Date facility began operation under current owner 1986

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	122	122 (SNNF Dually Certified)
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

(State)	Profit	Individual
County	(Nonprofit)	Partnership
City		Corporation
Private		(Sponsored)

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Mt. Lebanon Personal Care Home dba James S. Taylor Memorial Home
1015 W Magazine Street
Louisville, KY 40203

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation New Zion Baptist Church (Sponsor)

Address of corporation PO Box 11067 Louisville, KY 40251

President or Chairman Rev. A. Russell Awkard, Pastor

Vice President Mr. Harry Miller (JSTMH Board of Directors)

Secretary Mrs. Louise Rucker

Treasurer Mrs. Louise Rucker

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Stephanie L. Mathis — Signature of authorized representative

Administrator — Title

9-7-10 — Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)